Reply

In response to the letter from Dr. Shaw, we would like to clarify the disease status of the patients transplanted with the TBI/cytosine arabinoside conditioning regimen. Of the 14 patients with acute lymphocytic leukemia, eight patients had relapsed on therapy or within 3 months off treatment, 4 patients had relapsed between 7 and 19 months off treatment, and two patients were transplanted in first remission due to high-risk features. Of these two, one patient had Ph+ ALL; the other presented with features of lymphoma/leukemia, failed initial induction therapy and underwent transplantation while in remission after secondary induction chemotherapy. At the time of bone marrow transplantation, two patients were in first remission, 10 patients were in second remission and two were in second relapse.

Of the six remaining patients with ANLL, five were in first remission (3 with ANLL and 2 with acute mixed lineage leukemia) and one with AML was transplanted in resistant relapse. The comparison of our results with those obtained by Dr. Shaw is difficult to make because of small patient numbers and different patient characteristics and also because Dr. Shaw does not tell us what thedisease-free survival of his patients is at any time point.

Experience over the past two decades has shown that superior preparative regimens can decrease relapse rates post-transplantation albeit sometimes at the expense of higher regimen-related toxicity. Although ours was a pilot study, our follow-up is long enough to make us feel that the communication of our experience was warranted. All surviving patients continue to be in remission 38–108 months after transplantation (median 80 months). We agree that prospective randomized trials are necessary to address the important issues surrounding the role of preparative regimens in transplantation for malignant diseases. Cooperative groups and international registries should facilitate these prospective trials.

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Received October 25, 1995; accepted January 23, 1996.